ATTACHMENT "A"

STATE OF WYOMING SUICIDE PREVENTION PLAN

February 2006

Wyoming Suicide Prevention Task Force
Wyoming Department of Health
Mental Health & Substance Abuse Services Division

STATE OF WYOMING
SUICIDE PREVENTION PLAN
SAVING ONE LIFE

Introduction and Background

The devastating loss of human life by suicide and the accompanying grief, guilt, confusion and fear are all too familiar to many Wyoming families, friends, and communities. Suicide has always been a difficult topic to discuss. Although suicide involves multiple individual, social, and environmental factors, it is rarely random or inevitable. Suicide is a subject that is feared and misunderstood. However, through education, training, intervention, and treatment we can reduce the number of suicides within our state. SUICIDE IS PREVENTABLE in most cases.

Recognizing that suicide is a national problem that is preventable, the Surgeon General of the United States, declared suicide a serious public health issue. According to The Surgeon General's Call to Action to Prevent Suicide published in 1999, an average of 85 Americans die of suicide each day. Although more females than males attempt suicide, males are at least four times more likely to die of suicide.

The majority of Americans who die from suicide suffer from a major mental illness and/or a substance abuse disorder. More than 60% of all people who die by suicide suffer from major depression.[1] Stigma associated with major mental illness prevents many persons from seeking help. Approximately 70% of individuals suffering from major depression in a given year do not seek help.[2] Alcohol and/or other drugs are a factor in at least 30% of all suicides .[3]

Suicide affects men and women of all age ranges and racial backgrounds. Nationally, suicide is the 3rd leading cause of death among children 10-14 years of age, claiming more than 4,000 young lives each year. The suicide rate for this age group has increased 100% between 1980 and 1996.[4] The national incidence of suicide among youth age 15 - 24 years old has tripled in the last 40 years. More teenagers and young adults die of suicide than from cancer, heart disease, birth defects, and other illnesses combined.[5] There are an estimated 100-200 suicide attempts for every death by suicide among this age group.[6]

Did you know...?

- **Every 17 minutes someone dies by suicide in the United States.**
- **About 30,000 people die by suicide in the United States each year.**
- **Males are four times more likely to die of suicide than females.**
- **More than 90% of people who die by suicide suffer from mental illness and/or substance abuse.**
- **Suicides in the United Stated outnumber homicides by one-third.**
- **Stigma, cultural and religious factors sometimes prevent people from getting the help they need.**

Suicide in Wyoming

The rate of suicide in Wyoming has historically been high. According to the most recent national statistics available, Wyoming ranks fifth in the nation in the rate of suicide per capita. Data for 2004 indicate there were 84 suicides in our state that year, making the rate of suicide in the state 17.4 per 100,000 population. National rates have stabilized at about 11 per 100,000. Wyoming's rate of suicide historically has measured about twice that of the nation. In 2002 and 2003, Wyoming had the highest rate of suicide in the country

A firearm was used in 77% of all suicides in the state[7] as compared to about 57% nationally.[8] Firearms are the means of choice for both males and females in our state. Unsurprisingly, Wyoming ranks first nationally in the percentage of residents who keep firearms in the home (63%).

Among youth age 15 - 24, suicide is the second leading cause of death in Wyoming, following unintentional injuries. Although this age group represents only about 15% of the population in the State, approximately one-quarter of suicides are among youth aged 15 – 24 years. The rate of suicide for Wyoming youth is about 50% higher than the national rate for the same age group.

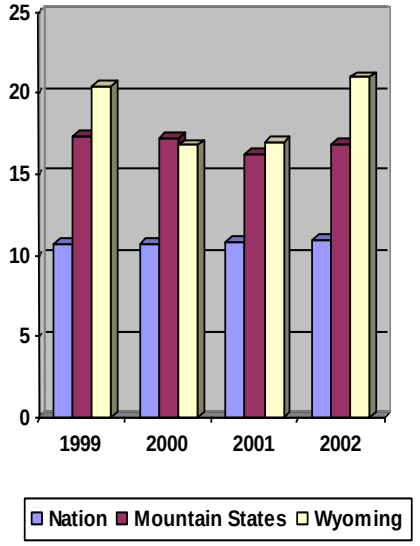
According to the Wyoming Youth Risk Behavior Survey conducted for the State Department of Education, 18.5% of high school students surveyed reported they considered attempting suicide during the twelve months prior to the survey. Twenty-two percent of middle school students reported they had thought about killing themselves. Seven percent of high school students surveyed and 9% of middle school students surveyed indicated they had actually attempted suicide one or more times during the twelve months preceding the survey. In addition to major mental illnesses and substance abuse, family histories of abuse, and violence are risk factors in teen suicide, as are unplanned pregnancies, runaway behavior and incarceration. Research suggests that gay and lesbian youth are at high risk of suicide, however, no definitive national studies have been conducted. Examination of this issue is complicated by the lack of accurate information on the rate of homosexuality nationally and by the conflicts generated by the topic. Suicide among youth is often an impulsive act.

Suicide is not only a problem among our youth. Wyoming statistics for 2003 indicate that suicide was the second leading cause of death for adults age 25 - 44. The rate of suicide among adults age 25 and older during 2003 in our state is 27.75 per 100,000. Research indicates that there are approximately 25 suicide attempts among adults for every death by suicide.[9]

Factors that may contribute to suicide in western, rural states:

- **Lack of family ties or other support systems**
- **Physical isolation**
- **Lack of sufficient numbers of mental health professionals**
- **Wide availability of firearms**

Rates of Suicide 1999-2002



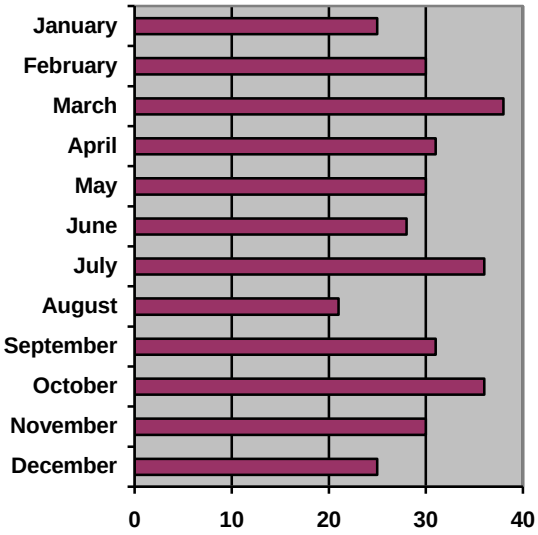
Applying this estimate, there were approximately 2250 suicide attempts among Wyoming adults during the year 2003.

Nationally, suicide rates increase with age and are highest among Americans 65 years of age and older .[10] Mental health and substance abuse issues are often not identified in the elderly or may be disguised by medications. Risk factors such as physical illness, death of a partner or friends, economic problems and lack of social support are often discounted as a fact of "growing old". Depressive illnesses are major risk factors for suicide in the elderly .[11] "Passive suicide" in which the older adult may stop eating or stop using medication is not uncommon. The elderly are the most likely to have visited a physician shortly before their suicide, providing an opportunity for intervention. Nineteen persons 65 years of age and over died by suicide in Wyoming during 2003.[12]

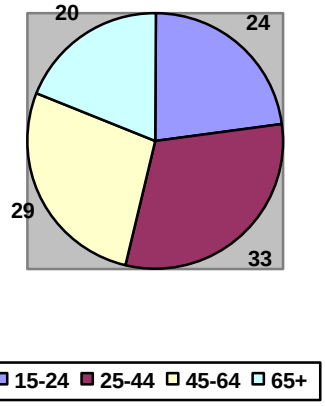
White males and white females account for more than 90% of all suicides nationally[13] and account for 97% of suicides in Wyoming. According to the National Center for Health Statistics, suicide rates are lowest among blacks and nonwhite (Hispanic and Asian) Americans. In 2000, the suicide rate among blacks was 5.6 per 100,000 population and among nonwhite the rate was 5.9 per 100,000 population. However, suicide rates for Native Americans (a category which includes American Indians and Alaskan Natives) are higher than national rates. Youth age 15 -24 have the highest rates among Native Americans, with an overall age-adjusted rate of 19.2 per 100,000 population.[14] Among Native Americans, suicide rates peak during the teen and early adult years and decrease around age 40.[15] Cultural factors, unemployment, poverty, mental illness and use of substances, particularly alcohol, are risk factors for suicide among Native Americans. Three percent of the suicides in Wyoming in 2002 were among Native Americans.

Suicide among young Hispanics is a growing concern. One study indicates that over 13% of Hispanic high school students reported making at least one suicide attempt in the year prior to the study, compared to 8.9% of non Hispanic blacks and 7.8% of non Hispanic whites.[16] Hispanic girls, in particular, are at high risk for suicide. The reported creation of a suicide plan and a suicide attempt requiring medical attention is highest among Hispanic female students.[17] According to a report from the National Alliance for Hispanic Health, one in three Hispanic girls has seriously considered suicide. This rate is the highest of any racial or ethnic group of the same age. The stressors of minority group status in combination with low self-esteem, and depression faced by many adolescents, are thought to be contributing factors to the escalating rate of suicide among female Hispanic youth .[18]

Suicide in Wyoming by Month 1999 - 2002



Wyoming Suicides by Age, 2002



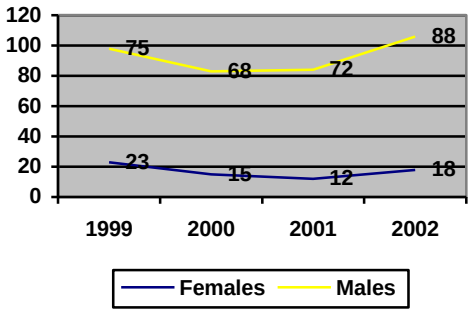
Suicide is the leading cause of death among inmates in jails, where more than 400 inmates per year take their own lives .[19]

Among jail inmates, the rate of suicide is approximately 9 times greater than in the general population.[20] According to a study conducted in 1999 by the Bureau of Justice Statistics, 16% of prison inmates across the United States are mentally ill. Although the rate of suicide in prisons is far lower than that in jails, the rate is disproportionately higher than in the general population.[21]

Research indicates that the scope of the problem is much larger than data indicate. The societal, religious, and cultural taboos against suicide affect the accuracy of reporting. Suicides are often listed as accidental deaths, overdoses, or other less stigmatized occurrences.[22] Real and perceived stigma creates pressure from families to label suicide as accidental or undetermined deaths.[23] Negative consequences involved with insurance claims, settlement of estates, workers' compensation claims and individual reputations all compound and encourage the under reporting of suicides.[24] Oftentimes, as in the case of automobile accidents, suicides are not distinguishable as such. Intentional or not, under reporting of suicides is estimated to range from 10% [25] to 33% .[26]

While Wyoming faces the same challenges as many other states in developing and implementing effective suicide prevention practices, there are demographic, cultural and geographic barriers to prevention that are unique to the State. Wyoming is profoundly rural in nature, having the second lowest population density in the nation (5.9 persons per square mile). Mental Health services are unavailable or significantly limited in many areas. Moreover, Wyoming has long-valued the "cowboy-up" philosophy that emphasizes rugged independence, self-reliance, and stoicism in the face of personal adversity. Because Wyoming residents commonly perceive mental illness as a personal weakness, those who suffer from depression or experience suicidal ideation may take their own life rather than risk the stigma of being diagnosed with and/or treated for a mental disorder.

Suicide Deaths by Gender



Suicide Rate by County 1999-2002

Albany	**14.06**
Big Horn	**23.99**
Campbell	**17.06**
Carbon	**30.37**
Converse	**20.74**
Crook	**25.48**
Fremont	**25.84**
Goshen	**21.93**
Hot Springs	**30.73**
Johnson	**14.13**
Laramie	**14.09**
Lincoln	**17.16**
Natrona	**21.79**
Niobrara	**0**
Park	**11.63**
Platte	**19.87**
Sheridan	**19.77**
Sublette	**8.45**
Sweetwater	**27.92**
Teton	**13.7**
Uinta	**10.13**
Washakie	**18.10**
Weston	**11.29**
State	**18.78**

SUICIDE PREVENTION TASK FORCE

The Wyoming Department of Health established the Suicide Prevention Task Force in response to the growing state and national public health concern over suicide and the probability that the rate is higher than reported. The Task Force is a public-private partnership reflecting state, local, private, and personal interests. We are a multi-disciplinary coalition whose members represent public and private sectors, families, and individuals touched by suicide. The mission of the Task Force is to improve the health and well being of Wyoming citizens over the life span by reducing suicide and its impact on individuals, families, and communities. The Task Force has successfully partnered with the United States Air Force, through F.E. Warren Air Force Base in Cheyenne.

The Task Force has researched risk factors related to suicide among youth, identified and reviewed numerous educational and intervention approaches that may impact youth suicide, and identified barriers to prevention and early intervention. In 1998 the Task Force conducted a statewide survey of suicide prevention activities in all Wyoming school districts.

Following the lead of the Suicide Prevention Advocacy Network (SPAN) and the national conference on suicide held in Reno Nevada in 1998, the Task Force planned and organized the first statewide conference on suicide, held in January 2000. The conference utilized national and regional experts on the topic of suicide, with emphasis on the elderly, youth, and Native Americans. The 211 participants included representatives from various human service agencies, health care providers, school personnel, law enforcement, legislators, clergy, families and survivors of suicide.

Following the conference, the efforts of the Task Force focused on the development of a statewide Suicide Prevention Plan. Members of the Task Force collected and reviewed suicide prevention plans developed by other states, as well as the National Suicide Prevention Strategy Draft Goals and Objectives. Written in 1999, the plan receives annual updates.

The Task Force has developed brochures, posters, and public service announcements that have been broadcast on Wyoming radio and TV stations to increase public awareness about suicide and provide information on suicide risk. A guide called *Suggested Guidelines for Wyoming Media on Reporting Suicide* was developed by Task Force members and distributed to the media. An informational display was created for use at conferences and training events in the State. The Task Force has published a quarterly newsletter on suicide and related topics, initiated in the fall of 2002.

Task Force Accomplishments:

- Created Wyoming's suicide prevention plan: *Saving One Life* in 1999, with annual updates.
- Provide funding to nine communities to establish suicide prevention coalitions and provide suicide prevention activities.
- Planned and sponsored two Wyoming conferences on suicide prevention.
- Developed and presented the Gatekeeper Training to over 600 people statewide
- Conducted a □Train the Trainer□ Gatekeeper event, and disseminated copies of the Gatekeeper Training to community coalitions.
- Created and distributed three types of brochures on suicide among youth, among the elderly, and among the general adult population. Over 30,000 brochures have been distributed.
- Developed *"Suggested Guidelines for Wyoming Media on Reporting Suicide"*
- Adapted radio and TV public service announcements and posters made available from the American Association of Suicidology
- Created an informational display for use at conferences and training events
- Developed and provided training on Suicide and Violence Risk Assessment
- Reviewed and recommended suicide risk assessment tools for physicians, senior centers, public health offices, and other locations where health status is assessed.
- Publish a quarterly newsletter.

Our partnership with members from the United States Air Force Base in Cheyenne resulted in the Gatekeeper Training, which was modeled after the successful suicide prevention program developed by the United States Air Force. The training has been provided to over 600 people since its development in late 2001.

A second training on suicide and violence risk assessment was developed and provided to mental health clinicians in January of 2003. The training was presented via videoconferencing with over 100 individuals at eleven sites participating.

In the 2005 General Session, the Wyoming Legislature authorized the creation of a permanent suicide prevention program within the Wyoming Department of Health. Pursuant to this legislative mandate, the position of Suicide Prevention Specialist was established within the Mental Health Division to coordinate suicide prevention efforts throughout Wyoming. The responsibilities of the Suicide Prevention Specialist include revising the State Suicide Prevention Plan, assisting local communities in establishing and maintaining suicide prevention coalitions, providing expert technical assistance on suicide prevention, maintaining a library of suicide prevention materials, and collecting and disseminating information on evidence-based programs and best practices in suicide prevention. The Suicide Prevention Specialist works collaboratively with the Suicide Prevention Task Force, local mental health centers, suicide prevention coalitions and other state agencies in the performance of these functions.

On December 1, 2005, the Wyoming Department of Health submitted to the Legislature its first annual report on the State Suicide Prevention Program. Among the program highlights for the year were (1) the revision and expansion of the State suicide prevention plan to include goals for improved surveillance and reporting and reduction of stigma associated with mental illness and suicide; (2) increased activities among local suicide prevention community coalitions and prospective coalitions; (3) creation of a suicide prevention website; (4) dissemination of quarterly suicide prevention newsletter; (5) formation of initiatives designed to reduce suicide among youth and Native American populations; (6) expansion of suicide prevention library to more than 500 materials; (7) increase in public awareness and education through gubernatorial proclamations, suicide awareness events and statewide media campaign; and (8) revision and reprinting of suicide prevention materials and brochures for mass distribution in the state. In 2005, the Wyoming Department of Health, Mental Health Division provided funding to ten local suicide prevention task forces providing services in eleven Wyoming counties.

Saving One Life GUIDING PRINCIPLES:

- Suicide is preventable in most cases.
- Suicide is a serious public health problem. A public health approach to suicide prevention will maximize efforts and resources.
- A sustained, long-term commitment is required to reduce suicide rates.
- The statewide plan must be considered in its entirety; piecemeal implementation may not be effective.
- Suicide is inter-related with other social complexities and cannot be impacted in isolation.
- A comprehensive response to suicide requires a continuum of services, i.e., prevention, intervention, and treatment.
- Suicide prevention and intervention activities must build on the strengths of individuals, families and communities.
- The development of health communities through comprehensive, collaborative, community-based approaches is required to reduce the rate of suicide.
- Suicide prevention and intervention strategies should be culturally and age appropriate and should reflect community values.
- Planning and implementation of suicide prevention and intervention activities should include the participation of individuals within the target population as well as survivors and families.
- Suicide prevention and intervention activities must be outcome based and include evaluation components.

The Department of Health's legislative report on suicide prevention also sets forth a number of recommendations for expansion of the state's public health approach to suicide prevention. These recommendations include the provision of funding for a statewide stigma reduction media campaign, expansion of local coalitions and school-based suicide prevention programming. More information on suicide prevention can be found at the Wyoming Department of Health suicide prevention website at http://wdh.state.wy.us/wspi/index.asp.

WYOMING'S SUICIDE PREVENTION TASK FORCE

RECOMMENDED SUICIDE PREVENTION STRATEGIES

These recommendations are guided by The Surgeon General's Call to Action to Prevent Suicide and the National Strategy for Suicide Prevention. Just as The Surgeon General's Call to Action is a blueprint for states to develop their own plans, this statewide plan is designed as a blueprint for communities to develop and implement research-based suicide prevention approaches that address their own unique community needs.

MISSION: REDUCE THE RATE OF SUICIDE IN WYOMING AMONG ALL AGE GROUPS AND CULTURES

GOAL 1: AWARENESS:
Promote awareness that suicide is a public health problem that is Preventable.

Potential sources of measurement data include but are not limited to: the number of education and training opportunities provided; the number of media reports made available; and the number of letters of support received.

Objective 1.1 Provide ongoing public education and training on suicide and its risk and protective factors to reduce the confusion and fear associated with suicide, increase public knowledge of suicide prevention, and promote help-seeking behaviors.

Method 1.11 Sponsor conferences and training events to increase the awareness of suicide prevention and increase inter-agency collaboration within communities.

Method 1.12 Develop and disseminate brochures and posters on suicide prevention that provide information on suicide risk factors and resources.

Method 1.13 Provide public service announcements on radio and television to disseminate information on suicide and suicide prevention.

Method 1.14 Develop and maintain suicide prevention information and intervention resources as part of the web site of the Mental Health Division.

Method 1.15 Provide education and training on suicide prevention to families and significant others whose loved ones are at risk of suicide.

Method 1.16 Provide training for community helpers, such as school bus driver, mail carriers, meter readers, taxi drivers, coaches, hairdressers, animal control officers, Meals on Wheels volunteers, senior service volunteers and faith leaders on how to recognize, respond to, and refer for help, people at risk of suicide and associated mental and substance abuse disorders.

Objective 1.2 Provide education to state, county, and local officials, including judges and court personnel, about suicide, suicidal behavior, mental illness and substance abuse and the associated impact on health care, social services, law enforcement, employment, corrections systems, etc.

Method 1.21 Develop and disseminate an annual report on the status of suicide and suicide prevention activities within the state.

Method 1.22 Develop and disseminate quarterly newsletters, directed at specific professional groups, such as school personnel, physicians, law enforcement, clergy, health care providers, etc.

Objective 1.3 Develop broad-based support for suicide prevention.

Method 1.31 Distribute Wyoming's Suicide Prevention Plan to stakeholder groups, private entities, professionals and the general public.

Method 1.32 Establish broad representation of various agencies, interest groups, and individuals and families on the Suicide Prevention Task Force.

Method 1.33 Increase the number of professional, volunteer, and other groups that integrate suicide prevention activities into their ongoing activities.

GOAL 2: AWARENESS:
Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.

Objective 2.1 Increase the proportion of the public that views mental and physical health as equal and inseparable components of overall health.

Method 2.11 Develop and implement a statewide and regional public awareness anti-stigma campaign.

Method 2.12 Provide local coalitions with technical assistance and resources necessary to develop and implement local anti-stigma efforts.

Objective 2.2 Increase the proportion of the public that views mental disorders as illnesses that respond to specific treatments.

Method 2.21 Collaborate with other participants and stakeholders in the mental health field to provide education and technical assistance regarding the need for parity in the provision of mental health services.

Objective 2.3 Increase the proportion of appropriate treatment provided to those suicidal with underlying disorders.

Method 2.31 Provide ongoing information and training to members of the public, primary care physicians and other health-care providers, and community gatekeepers on the casual link between mental illness and suicidality.

Method 2.32 Provide information on screening, assessment and referral of individuals at risk of suicidal behaviors.

GOAL 3: INTERVENTION: Develop and implement community-based suicide prevention programs and activities.

Potential sources of measurement data include but are not limited to: community mental health centers; hospitals, senior citizen centers, and suicide prevention programs.

Objective 3.1 Increase the number of communities with suicide prevention coalitions.

Method 3.11 Provide funding to communities to establish coalitions for the purpose of implementing suicide prevention and intervention activities.

Method 3.12 Provide technical assistance to communities to assist in the development of coalitions and in planning and implementing suicide prevention activities.

GOAL 4: INTERVENTION:
Promote efforts to reduce access to lethal means and methods of self-harm.

Objective 4.1 Promote and encourage safe storage of firearms, medications, and toxic substances and the use of trigger locks.

Method 4.11 Develop a public education campaign in conjunction with the National Rifle Association and public health.

GOAL 5: INTERVENTION:
Implement training for recognition of at-risk behavior and delivery of effective treatment.

Objective 5.1 Increase the number of higher education institutions that provide course work on suicide, mental illness and substance abuse as a required component.

Objective 5.2 Increase the number of professional groups such as law enforcement officers, dispatchers, correctional facility personnel, mental health and substance abuse professionals, psychologists, nurses, physicians, emergency medical technicians and other health related occupations, which require training on suicide risk assessment and recognition, suicide intervention, and aftercare as a prerequisite for certification/licensure.

Objective 5.3 Train emergency room personnel to routinely assess suicide risk among individuals who have experienced psychological trauma such as physical or sexual.

Objective 5.4 Increase the number of educators and school personnel who receive periodic in-service training on recognizing the signs and risk factors of suicide and how to facilitate appropriate interventions.

Objective 5.5 Increase the number of mental health professionals who receive training on suicide and violence risk assessment.

Method 5.51 Develop and provide periodic training events on suicide and violence risk assessment.

GOAL 6: INTERVENTION:
Increase access to and community linkages with mental health and substance abuse services.

Objective 6.1 Increase the number of schools statewide that provide suicide prevention programming as part of the curricula.

Objective 6.2 Improve crisis response systems.

Objective 6.3 Increase the availability of depression screening in primary health care settings.

Method 6.31 Fund pilot projects to increase collaboration between primary health care professionals and mental health professionals.

Objective 6.4 Increase the number of primary health care providers who recognize and refer for treatment, individuals with depression, other major metal illnesses and substance abuse.

Method 6.41 Fund pilot projects to increase collaboration between primary health care professionals and mental health professionals.

Objective 6.5 Increase the number of schools that provide mental health services on-site, independent of school guidance functions, special education functions, and testing functions, etc.

Objective 6.6 Increase the number of schools, colleges, and universities with crisis responses management plans that include suicide intervention and postvention activities.

Objective 6.7 Increase access to community-based mental health services and programs.

Method 6.71 Provide funding for adequate programming and staffing of community mental health service systems to provide best practice of care within a continuum of care.

Objective 6.8 Increase the number of insurance plans that provide mental health benefits.

Objective 6.9 Develop strategies to improve access to psychotropic medications.

Objective 6.10 Increase the proportion of homeless shelters, correctional programs, group care facilities, nursing homes, youth crisis centers and foster care programs that provide referral to mental health and substance abuse services.

Objective 6.11 Increase mental health services to populations at highest risk of suicide.

Method 6.111 Target older adults, youth, and middle-aged men for increased outreach and suicide prevention activities.

Method 6.112 Develop effective mental health interventions for persons who are deaf or hard of hearing.

Objective 6.12 Increase the number of communities with support programs for suicide survivors.

GOAL 7: INTERVENTION:
Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the news media.

Objective 7.1 Develop partnerships with the media to facilitate publication and dissemination of information on suicide and its risk and protective factors.

Method 7.11 Develop and disseminate a guide for media on the reporting of suicides, in accordance with the media guidelines developed by the American Association of Suicide and Centers for Disease Control and Prevention.

Method 7.12 Assist the media in the development of articles, programs, and radio shows about suicide prevention.

GOAL 8: METHODOLOGY:
Promote and support research on suicide prevention.

Potential sources of measurement data will be available through coordination of suicide data with other western rural states; and collaborations between the Wyoming Department of Health, Department of Education, Department of Family Services, public and private agencies, and advocacy groups.

Objective 8.1 Establish processes to keep abreast of and disseminate to community coalitions, the most recent research studies on suicide and the risk factors for suicidal behaviors.

Objective 8.2 Improve the collection and reporting of suicides and suicide attempts by state and local authorities.

Objective 8.3 Develop an ongoing evaluation component for each prevention and intervention strategy implemented.

Method 8.31 Pursue technical assistance on evaluation and outcome measures, for the state task force activities and community coalition activities.

GOAL 9: METHODOLGY:
Improve and Expand Surveillance Systems.

Objective 9.1 Develop and refine standardized protocols for death scene investigations and implement these protocols in counties.

Method 1.1 Collaborate with county coroners, law enforcement personnel, emergency responders, treating physicians and medical staff, and vital records personnel to improve investigation and reporting of deaths by suicide.

Objective 9.2 Implement a State Violent Death Reporting System that includes suicides and collects information not currently available from death certificates.

Method 9.21 Pursue federal funding to become a participating state in the National Violent Death Reporting System sponsored by the Centers for Disease Control and Prevention's National Center for Injury Prevention and Control.

Wyoming Suicide Prevention Task Force

SUICIDE RISK AND PROTECTIVE FACTORS

RISK FACTORS

Understanding risk factors can help dispel the myths that suicide is a random act or results from stress alone. Some persons are particularly vulnerable to suicide and suicidal self-injury because they have more than one mental disorder present, such as depression with alcohol abuse. They may also be very impulsive and/or aggressive, and use highly lethal methods to attempt suicide. The importance of certain risk factors and their combination vary by age, gender, and ethnicity.

The impact of some risk factors can be reduced by interventions. Those risk factors that cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of recurrence of a mental or substance abuse disorder, or following a significant stressful life event.

Risk factors include:

- Previous suicide attempt
- Mental disorders, particularly mood disorders such as depression and bipolar disorder
- Co-occurring mental and alcohol and substance abuse disorders
- Family history of suicide
- Threats of suicide
- Hopelessness
- Impulsive and/or aggressive tendencies
- Barriers to accessing mental health treatment
- Relational, social, work, or financial loss
- Physical illness
- Easy access to lethal methods, especially guns
- Unwillingness to seek help because of stigma attached to mental disorders, substance abuse disorders, and/or suicidal thoughts

- < Influence of significant people - family members, celebrities, peers who have died by suicide - both through direct personal contact or inappropriate media representations
- < Cultural and religious beliefs - for instance, the belief that suicide is a noble resolution of a personal dilemma
- < Local epidemics of suicide that have a contagious influence
- < Isolation, a feeling of being cut off from other people

Adverse life events in combination with other strong risk factors such as mental or substance abuse disorders and impulsivity, may lead to suicide. However, suicide is not a normal response to the stresses experienced by most people. Many people experience one or more risk factors and are not suicidal.

PROTECTIVE FACTORS

Protective factors can include an individual's genetic or neurobiological makeup, attitudinal and behavioral characteristics, and environmental attributes. Measures that enhance resilience or protective factors are as essential as risk reduction in preventing suicide. Positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing.

Protective factors include:

- < Effective and appropriate clinical care for mental disorders, physical disorders, and substance abuse disorders.
- < Easy access to a variety of clinical interventions and support for help seeking.
- < Restricted access to highly lethal methods of suicide.
- < Family and community support.
- < Support from ongoing medical and mental health care relationships.
- < Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes.
- < Cultural and religious beliefs that discourage suicide and support self-preservation instincts.

Source: U.S. Public Health Service, *The Surgeon General's Call to Action to Prevent Suicide.* Washington, D.C.: 1999.

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MENTAL HEALTH RESOURCES IN WYOMING

Northeastern Wyoming:

< BUFFALO: Northern Wyoming Mental Health Center, 521 West Lott, (307) 684-5531
< GILLETTE: Campbell County Memorial Hospital Mental Health Services 501 S. Burma Avenue, (307) 685-7888
< GILLETTE: Campbell County Memorial Hospital Inpatient Services 501 S. Burma Avenue, (307) 682-8811
< NEWCASTLE: Northern Wyoming Mental Health Center, 420 Deanne Avenue, (307) 746-4456
< SHERIDAN: Northern Wyoming Mental Health Center 101 W. Brundage , (307) 674-4405
< SUNDANCE: Northern Wyoming Mental Health Center, 209 Cleveland, (307) 283-3636

Northwestern Wyoming:

< BASIN: Big Horn County Counseling, 220 S. 4th Street, (307) 568-2020
< CODY: Park County Mental Health Center, 1220 Sunshine Avenue, (307) 587-2197
< CODY: West Park Hospital, 707 Sheridan Avenue (307) 527-7501
< LOVELL: Big Horn County Counseling, 441 Montana, (307) 548-6543
< POWELL: Park County Mental Health Center, 639 Avenue H, (307) 754-3448
< THERMOPOLIS: Hot Springs County Counseling Service, 121 South 4th, (307) 862-3138
< WORLAND: Washakie Mental Health Services, 206 S. 7th Street, (307) 347-6165

Southeastern Wyoming:

< CHEYENNE: Southeast Wyoming Mental Health Center, 2526 Seymour, (307) 634-9653
< CHEYENNE: United Medical Center Behavioral Health Services, 2600 E. 18th (307) 633-7370
< LARAMIE: Southeast Wyoming Mental Health Center, 710 Garfield, Suite 320, (307) 745-8915
< LARAMIE: Ivinson Memorial Hospital Behavioral Health Services, 255 North 30th, (307) 742-3322
< RAWLINS: Carbon County Counseling Center; 721 Maple, (307) 324-7156
< TORRINGTON: Southeast Wyoming Mental Health Center 1942 East D Street, (307) 532-4091
< WHEATLAND: Southeast Wyoming Mental Health Center, 1-3 Park Avenue, (307) 322-3190

Southwestern Wyoming:

< AFTON: Lincoln County Mental Health Association, Hospital Lane, (307) 885-9883
< EVANSTON: Pioneer Counseling Services, 350 City View Drive, Suite 302, (307) 789-7915
< EVANSTON: Wyoming State Hospital, (307) 789-3464
< GREEN RIVER: Southwest Counseling Service, 175 Riverview Drive, (307) 872-3205
< JACKSON: Jackson Hole Community Counseling Center, 115 W. Snow King, (307) 733-2046
< JACKSON: St. John□s Hospital 625 E. Broadway, (307) 733-3636
< KEMMERER: Lincoln County Mental Health Association; #230 Hwy 233, (307) 877-4466
< LYMAN: Pioneer Counseling Services, 303 South Main, (307)786-2105
< ROCK SPRINGS: Southwest Counseling Service, 1124 College Road, (307) 352-6677
< PINEDALE: Sublette Community Counseling Services, 41 □ South Franklin, (307) 367-2111

Central Wyoming:

< CASPER: Central Wyoming Counseling Center, 1200 East 3rd Street, Suite 330, (307) 237-9583
< CASPER: Wyoming Behavioral Institute, 2521 E. 15th, 1-800-457-9312
< DOUGLAS: Eastern Wyoming Mental Health Center, 1841 Madora, (307) 358-5329
< GLENROCK: Eastern Wyoming Mental Health Center, 925 W. Birch, (307) 436-8335
< LANDER: Fremont Counseling Service, 748 Main, (307) 332-2231
< LANDER: Pineridge at Lander Valley Medical Center, 1320 Bishop Randall Dr, (307) 332-5700
< LUSK: Eastern Wyoming Mental Health Center, 521 East 10th, (307) 334-3666
< RIVERTON: Fremont Counseling Service, 1110 Major Avenue,(307) 856-6587

ADVOCACY ORGANIZATIONS:

< WYOMING ALLIANCE FOR THE MENTALLY ILL 1-888-882-4968
< UPLIFT: (307) 778-8686

Physicians, psychiatrists, law enforcement and clergy are also available to help. Check your local telephone directory for listings.

Suicide Prevention Web Sites

American Academy of Pediatrics, Information on Suicide: www.aap.org/visit/suicideinfo.htm

American Association of Suicidology: **www.suicidology.org**

American Foundation for Suicide Prevention: **www.afsp.org**

Center for Disease Control Suicide Statistics: **www.cdc.gov**

Children□s Safety Network: **www.injuryprevention.org**

Critical Illness and Trauma Foundation: **www.citmit.org/index2.htm**

Emergency Medical Services for Children: **www.ems-c.org**

Intermountain Regional Emergency Medical Services: **www.citmt.org/irec**

National Institute of Mental Health Suicide Research Consortium: **www.nimh.nih.gov/research/suicide.htm**

National Center for Health Statistics: **www.cdc.gov/nchs**

National SAFE KIDS Campaign: **www.safekids.org**

Suicide Awareness Voices of Education: **www.save.org**

Suicide Information and Education Centre: **www.siec.ca**

Suicide Prevention Advocacy Network: **www.spanusa.org**

Suicide Prevention Triangle: **www.suicidepreventiontriangle.org**

Yellow Ribbon Suicide Prevention Program: **www.yellowribbon.org**

Depression/Mental Illness Web Sites

Administration on Aging: www.aoa.dhhs.gov/aoa/eldractn/deprssn.html

American Psychiatric Association: www.psych.org

American Psychological Association: www.apa.org

Division of Behavioral Health, Wyoming Department of Health: www.mentalhealth.state.wy.us

Health Connecting Mental Health Resources: www.athealth.com

Knowledge Exchange Network: www.mentalhealth.org

National Alliance for the Mentally Ill: www.nami.org

National Depressive and Manic-Depressive Association: www.ndmda.org

National Depression Screening Project: www.mentalhealthscreening.org/asha.htm.

National Institute of Mental Health: www.nimh.nih.gov

National Mental Health Association: www.nmha.org

Mental Health Infosource: www.mhsource.com

Screening for Mental Health, Inc.: www.nmip.org

Substance Abuse and Mental Health Services Administration: www.samhsa.gov

DISCLAIMER: Web sites are provided for informational purposes only.